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How do medical managers in English hospitals strategize? A Strategy-as-Practice perspective

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Abstract

Strategic planning (SP) is a widely-used practice within public sector organizations. However, SP does not only take place in strategy workshops and senior management levels. This article explores how medical managers of English hospitals 'do' SP in their clinical directorates. In doing so, the authors investigate the practices, the usage of strategy tools and the implications of medical managers' strategizing. The article argues that what makes financial sense to medical managers strategizing in the local circumstances of their directorates does not always equate to value for patients, the hospital or for the public sector as a whole.

Keywords: strategic planning, strategizing, medical manager, strategy tools, artefacts, profitability

Introduction

Strategic planning (SP) is an approach that public organizations commonly employ to formulate strategy. It involves the deliberative and systematic use of various concepts, techniques and tools to assess the organization's environment and determine its strategic direction (Bryson, 2018; George, 2017). Public management and strategy research has primarily focussed on formal SP (Nutt and Backoff, 1993; Poister et al., 2013), exploring how strategy is developed at the top management levels via formalized processes which lead to clearly articulated, explicit strategic plans. It has been argued, however, that top managers are not the only practitioners of strategy; strategy also forms through practices outside strategy workshops and board meetings (Jarzabkowski et al., 2007; Mantere, 2008). Yet, there is still little empirical evidence investigating how middle managers 'do' SP, which activities are involved in their strategy-making and if such SP is effective in a public sector setting.

This study addresses these gaps by investigating the numerous ways in which medical managers in English hospitals engage in SP. In doing so, we draw from the recent Strategy-as-Practice (SAP) perspective, which views strategy not as something that an organization has, but as something that its members do (Whittington, 1996; 2003), thus treating strategy as an emergent, socially situated practice. SAP focuses on the notion of strategizing, which broadly explores "*the doing of strategy; who does it, what they do, how they do it, what they use, and what implications this has for shaping strategy*" (Jarzabkowski and Spee, 2009, p. 69). We position our paper within the conceptual framework of George and Desmidt (2014) which explores how strategic-management processes take place in public sector organizations. This framing allows us to focus on the strategy work (i.e. strategizing) of practitioners of strategy, their use of material artefacts and tools and the various strategic practices in which they engage upon, through which actors realise their strategic intent. In doing so, we further shed light on the various implications of SP on public sector organizations.

The specific questions which drive the research are:

1. How do medical managers in English hospitals strategize?

2. Which strategy tools and artefacts do medical managers use?

3. What are the implications of medical managers' strategizing on the organization and the public sector?

We focus on English hospitals to recount the strategizing of both Clinical and Medical Directors, collectively referred to as medical managers, a hybrid group with dual professional-manager identity (Kurunmäki, 2004; Jacobs, 2005) who occupy a space opened up through the mediation of medicine and management in organizational roles (Llewellyn, 2001; Kirkpatrick et al., 2012). Our research findings are primarily based on interviews with medical managers at four English hospitals.

English hospitals are pluralistic organizations which provide a conducive environment for strategizing to occur, due to the existence of diverse goals and the complexity of applying top-down decision approaches (Denis et al., 2006). This context is common among many European public organizations where there are diverse identities, knowledge-led activities and a professional culture that may lead employees to pursue opportunities as they arise and develop strategies that may contest the formal organizational strategy (Bryson, 2018). Thus, the findings of this paper can alert managers and policy-makers to the implications of strategizing when they undertake strategic planning for healthcare organizations.

The Strategy-as-Practice perspective

Strategy research has often treated the formulation of strategy as a 'black box' (Johnson et al., 2003; Chua, 2007), which is created at the top management levels and implemented intentionally in a top-down fashion (Jarzabkowski et al., 2007). The SAP perspective emerged amid growing discontent with traditional strategy research; SAP widened the latter's narrow focus to encompass actors' micro-practices and micro-action which enact and shape strategy (Johnson et al., 2003).

The SAP perspective describes strategy as "*a situated, socially accomplished activity arising from the actions and interactions of multiple level actors*" (Jarzabkowski, 2005, p. 6). This definition treats strategy as a social practice (Whittington, 1996) and implies that strategy is something that actors do in their day-to-day, week-to-week activities (Johnson et al., 2003; Jarzabkowski et al., 2007; 2013). These actors, however, are not limited to the upper echelons of an organization since strategizing agency is highly distributed among various organizational levels (Mantere, 2005; Vaara and Whittington, 2012).

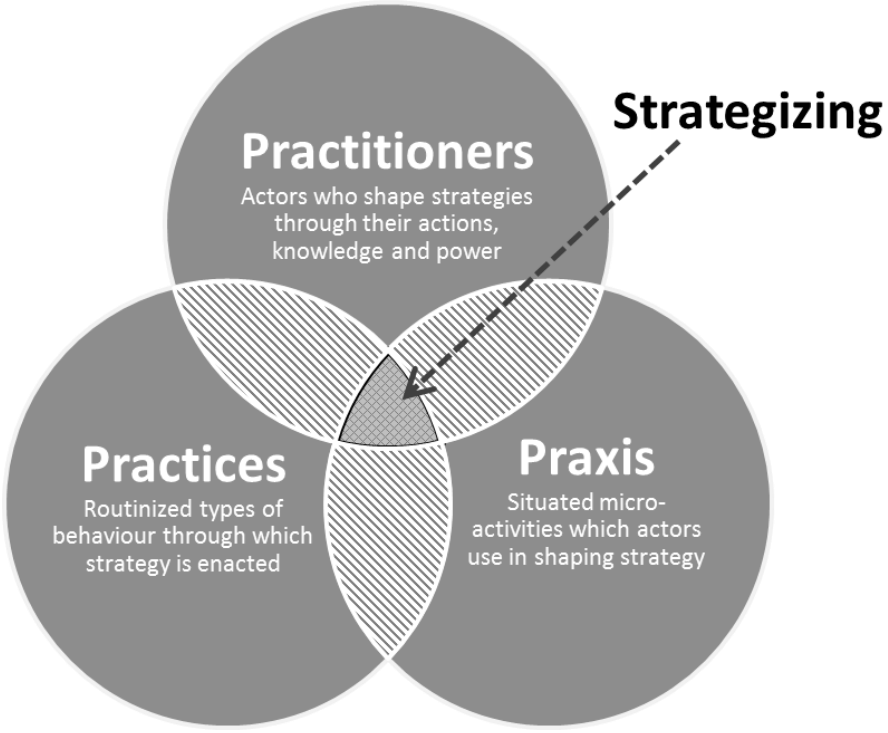
SAP studies investigate the activities of actors who are involved in formal and explicit strategy-making (Vaara and Whittington, 2012, p. 290), however "*strategy-making does not always involve the necessary formulation of goals, mental maps or plans*" (Chia and MacKay, 2007, p. 238). Furthermore, informal strategizing is encouraged by the traditional absence of formal objectives in public sector organizations rendering strategic agendas mere 'shopping lists' that do not provide a clear plan of action (Langley, 1986; Mintzberg, 2000; Llewellyn and Tappin, 2003). Indeed, public

sector strategy may often be only partially intended and therefore emergent (Joyce and Drumaux, 2014; Mintzberg, 1978). Practice scholars suggest that strategy is immanent in everyday operational actions, in the sense that actors display consistent strategic purpose when they deal with ordinary organizational tasks (Chia and Holt, 2006). Consequently, strategy and strategists are often only retrospectively understood through situated practices (Tsoukas, 2010).

Practice-praxis-practitioner framework

We engage with the SAP perspective to explore SP at the micro and meso levels, through employing a practice-praxis-practitioner framework, as suggested by Whittington (2006) and developed further by Jarzabkowski et al. (2007), Jarzabkowski and Spee (2009) and George and Desmidt (2014). The framework suggests that, by investigating strategy practitioners, practices and praxis, researchers are able to better understand strategizing, which comprises the nexus between the three distinct concepts (figure 1).

Figure 1. A theoretical framework for investigating strategizing (adapted from Jarzabkowski et al., 2007)



The notion of strategy practitioners refers to the organizational actors who develop, shape and implement strategies. When these actors strategize, they proactively manifest their strategic intent through planning and performing their everyday operations in certain ways (Mantere and Sillince, 2007), in an attempt to navigate their organizations towards a specific strategic direction (Hamel and Prahalad, 1990; Llewellyn, 2001). The notion of practice has been defined as an "*array of activity"* (Schatzki et al., 2001, p.11) such as the "*planning, resource allocation, monitoring and control practices and processes through which strategy is enacted'* (Jarzabkowski and Fenton, 2006, p. 632). For example, the practice of strategic planning can lead to organizational cohesion (Jarzabkowski,

2003) and even sabotage strategic change (Hendry et al., 2010). Praxis refers to the actions themselves; the micro-activities that the actors engage upon, such as the discourse, tools and artefacts that actors use during strategy formulation, implementation and evaluation (George and Desmidt, 2014). Research on praxis has focused on tools and artefacts such as Porter's five forces, the BCG (Boston Consulting Group) matrix and SWOT analysis (Spee and Jarzabkowski, 2009; Jarzabkowski and Kaplan, 2015), the use of Lego bricks and PowerPoint presentations in meetings (Heracleous and Jacobs, 2008; Kaplan, 2011), however the impact of praxis on public sector organizations has been underexplored (George and Desmidt, 2014).

We apply the practice-praxis-practitioner framework in our empirical setting to explore how medical managers (i.e. practitioners) in English hospitals formulate strategy (i.e. practices) and which socio-material and discursive tools and artefacts they use (i.e. praxis). We also track the implications of their strategizing on the organization and the public sector as a whole. Before we address our research objectives, however, we provide some detail on our empirical setting.

Research background

Clinical engagement with management practices has been at the forefront of the English National Health Service (NHS) for many decades. In the early 1990s, the British government introduced clinical directorates in English hospitals, with the intention to engage clinicians with managing their specialties (Kirkpatrick et al., 2012). Experienced clinicians were appointed as Clinical Directors and were given the authority and discretion to manage their clinical directorates as semi-autonomous business units (Llewellyn, 2001; Nyland and Pettersen, 2004). Thus, Clinical Directors were responsible for managing their directorate's budget and human resources, and were accountable for delivering on targets and their directorate's overall operational performance (Kirkpatrick et al., 2012).

In 2003, the government also introduced Payment by Results (PbR), a funding system in which healthcare commissioners reimburse healthcare providers for the activity they undertake, by using average treatment costs to set national reimbursement tariffs (Department of Health, 2002). Local tariffs may also be negotiated between providers and commissioners when a national tariff has not been set or is thought not to adequately reimburse treatment costs. PbR also presents healthcare providers with incentives to improve their clinical engagement and cost efficiency, since it allows hospitals to retain any funding surplus they have achieved, if the cost of a provided service is less than its corresponding tariff, conditional on maintaining or improving the required standards of care (Street and Maynard, 2007).

Following the PbR initiative, profit centres were introduced in English hospitals through Service Line Reporting (SLR), a new performance measurement system which identified the profitability of a hospital's service lines. Monitor, the former sector regulator for healthcare services in England, defines service lines as "*the natural "business unit" of the hospital- a distinct unit with identifiable customers, products, revenues and costs that is run as an independent business with its own income and expenditure*" (Monitor, 2006, p.1). In addition, the economic regulator introduced Cost Improvement Programmes (CIPs) to achieve cost savings of an average of 5% per year, with the

intention to enhance sustainability and efficiency (Monitor, 2012). CIP schemes are part of the annual strategy plans of English hospitals and CIP objectives are diffused across hospitals' specialties.

We argue that the treatment of service lines as profit centres and the introduction of cost improvement objectives have clear implications for SP practices. The pursuit of financial success for a service line inevitably shapes medical managers' strategic intent and directs their strategies towards maximising service line income and/or minimising its costs. For example, in search for service line profitability medical managers can contest attributed costs and seek investments to improve their income through increased patient activity. A key issue is how service line profitability and cost improvement objectives drive medical managers' strategizing as they address everyday difficulties which relate to the performance of their service lines.

Methodology

The research was exploratory and interpretive in nature. We conducted interviews at four selected public hospitals that demonstrated a high level of engagement between clinicians and finance professionals at different organizational levels and across clinical specialties. Our four cases (anonymized as Alpha, Beta, Gamma and Delta) are representative of a broader category of cases since 56% of all English hospitals display similar high engagement levels (Department of Health, 2016).

We conducted 38 semi-structured interviews. Specifically, we interviewed 24 Clinical Directors, 2 Medical Directors, 4 Senior Consultants, 2 Finance Directors, 9 Business Managers and 2 Chief Executives. Five of the interviews were carried out on a dyad basis with Clinical Directors and their Business Managers. We audio-recorded all interviews, except for a single interview where recording permission was denied and notes were taken instead. Recordings were transcribed verbatim. We also collected documents from all case study sites, such as business cases, strategy and financial reports, minutes from Board meetings, staff training and seminar presentations.

Thematic analysis was employed to analyse our data, identify and organize coded themes, trends and patterns from the analysed text (Guest et al., 2011). A total of three iterations of thematic analysis took place. First, the raw interview transcripts, collected documents and secondary data were grouped by case study site and were coded by organizing segments of text into themes, a process which led to the generation of multiple themes. This round exhausted all data from a single case site, before proceeding to the next, to obtain a general understanding of the depth and meaning of the empirical content and the sites' context. A second round of analysis focused on the produced themes. Different themes that shared the same context or had similar meaning were grouped together. A third and final round of analysis focused on the connections between the themed data and reviewed theories, in order to map out the emergent themes against our praxis-practitioner-practice framework. At this point, we pinpointed the strategic intent in our actors' practices and praxis to identify strategizing behaviour. Consequently, we report on medical managers' micro-actions which aim to realise their strategic intent, for example, achieving cost improvement objectives and improving the financial positioning of their specialty.

The qualitative software NVivo assisted in generating codes, on the segmentation of text and in describing, labelling and grouping together different themes. All aspects of data analysis were the outcome of manual coding. NVivo allowed the researchers to quickly navigate between the 590 pages of transcripts and acquire a clear sense of the richness and magnitude of the analysed data in each theme and case study site.

In the following section we discuss our findings on practitioners, practices and praxis through presenting medical managers' controlling, contesting and competing practices, their use of business cases and bubble charts, and the overall implications of medical managers' strategizing.

Medical managers' strategizing practices

Our first research question asks *"How do medical managers in English hospitals strategize?*". Our data analysis revealed that medical managers strategize via three main practices, namely through controlling, contesting and competing practices.

Strategizing via controlling practices

First, medical managers strategize via controlling practices to exert control over resources within their clinical directorates. Specifically, our analysis suggests that medical managers strategize through controlling activity and expenditure, to improve their directorates' cost-efficiency, increase income and achieve cost improvement targets. Interviews and collected documentation suggest that all of our case study sites had similar CIP objectives which were diffused across clinical directorates, mandating them to achieve cost savings of 4-5% each year. For example, the Chief Executive of Delta commented:

> *"…most [hospitals] are 4%, but because we've got various sort of catch-ups to do in terms of getting back into balance and to get to a small surplus at the end of this year… we're around 4.7%."* [CE-D]

Clinical Directors who head clinical specialties are responsible for meeting CIP objectives at the divisional level. Although they do not determine the level of the CIP target, Clinical Directors are still responsible for their directorates' short-term and long-term clinical and financial strategies, which they debate over meetings and away-days with colleagues, the Medical Director and other senior management members.

> *"[The CEO] wants us to have a strategy for the next five years […] So yes, over the last three years I've been drawing the annual plan for the department, both clinical and financial, because we have to identify the cost saving. We have the CIP that we need to identify."* [CD1-A]

Medical Directors are involved in meeting both hospital-wide and divisional-level CIP targets. This is evidenced by the Medical Director of Alpha:

> *"…I have executive responsibility for surgery. So we had our CIP that we had to meet, a whole raft of schemes. But if you drill down from those schemes, within the division, they would be*

down to specific services… So I had two roles. One, my own division, and obviously CIP, but also the [hospital]-wide CIP." [MD-A]

Our analysis suggests that medical managers in only one case study site were allowed to increase activity and income to meet CIP targets. A far more common practice in all case study sites, however, was controlling expenditure. Medical managers often strategized towards achieving CIP targets by controlling spending behaviour and cutting down on the number of prescribed drugs, ordered investigations and consumables employed. A medical manager at Gamma explained how his hospital did not allow specialties to achieve CIP objectives by increasing activity, but only via cost savings. He highlights the impact on clinicians and claims higher quality of care for patients.

"[H]igh quality does tend to be cheaper… Just chase the quality and forget about the cost attached to it. [M]ost quality measures tend to be in alignment with costs savings... You can't say, "To keep our CIP target by having the same costs, I'm doing 4% more". Last year that wasn't allowed." [CD1-G]

In addition, medical managers often attempted to control spending behaviour by comparing the volume of investigations between senior consultants and junior doctors, since the latter may prescribe unnecessary investigations and administer costly drugs due to their lack of experience. For example, a medical manager at Beta explained how engaging in conversations with clinicians can further reduce expenditure while improving quality of care.

"Where you want to start the conversation is, "Do you really act on this result every day? If you don't need it every day, then stop doing it every day." It's not kind of written in stone that just because they're sitting in a bed you've got to have to go up and stick a needle in them." [CD1-B]

Overall, medical managers realised their strategic intent via engaging in everyday controlling practices to navigate both their specialties and organizations towards improving cost efficiency and achieving cost improvement targets.

Strategizing via contesting practices

Second, medical managers engage in contestation practices through which actors challenge rules around cost and income. Specifically, medical managers often contested the tariffs that their specialties receive as reimbursement and their specialties' attributed costs. The strategic intent of such contestation practices is to reduce the attributed costs and increase the reimbursement money that their specialty receives from healthcare commissioners, thus aiming to improve the financial position of the specialty within the hospital.

Specifically, medical managers in all case study sites were often dissatisfied with the costs that are attributed to their specialty. They identified allocation inefficiencies and inequalities between specialties and engaged in, often strenuous, negotiations with Finance on altering the cost attribution process. In one case, a medical manager at Alpha and his business manager challenged the attributed costs by demonstrating erroneous coding that led to costs being attributed to the wrong specialty. The business manager explained:

> *"… [W]e're able to do a data claim and say, "Well, there might be some consultants who are classed as, let's say, spinal, but they were neurosurgeons." So all the activity was going to Neurosurgery, all those costs were going to Neurosurgery."* [BM1-A]

Medical managers also often contested claims from Finance that their specialty was unprofitable, ascribing their financial performance to the poor quality of costing information and inaccurate cost attribution. For example, a medical manager at Beta indicated that:

> *"…[Finance] will say, "The directorate is unprofitable." I take no notice of that at all… in the sense that I know that there are certain costs attributed to us that should be distributed across the organisation."* [CD1-B]

Furthermore, our analysis revealed instances where medical managers strategized to improve the financial position of their specialty via challenging the tariff through practices which may have perverse implications for patient care and the public sector as a whole. Specifically, medical managers in all four case study sites often critiqued the fairness of the funding mechanism and indicated discrepancies between the cost of treatment and reimbursement from healthcare commissioners. They sometimes engaged in dialogue with commissioners to negotiate for a better local tariff. For example, a Clinical Director at Beta and his business manager, in close collaboration with the contracting department, commenced negotiations on funding mastectomies and breast reconstruction separately, while performing both procedures simultaneously to maintain the quality of provided care.

> *"[Mastectomy and breast reconstruction] were essentially two cases absorbed into one, and it meant that we only got income for one case… [We] were able to demonstrate […] to our commissioners, actually, this is costing us a lot of money to do, but this is the gold standard. We could separate these cases out, and we could charge you twice. But that would be the wrong thing to do. It's clinically worse to put a patient through two anaesthetics, two surgeries… But we, financially, cannot continue to deliver in this way… But what was agreed subsequently was a local tariff agreement to say, we'll essentially pay for two procedures…'* [BM1-B]

In this example, the goals of pursuing service line profitability and maintaining quality in patient care were incongruent. This was resolved through the medical manager's successful negotiations with commissioners.

There were a few instances, however, where medical managers covertly contemplated how to increase their specialties' income through gaming the funding system. In a first example, the medical manager of Critical Care at Gamma claimed that Finance overcharges his directorate to alleviate the attributed costs to the Chemotherapy and Radiotherapy directorates. The motivation behind such an action lies in the fact that Gamma provides tertiary services, therefore Chemotherapy and Radiotherapy are partially funded based on national tariffs set by NHS England. Thus, the medical manager claims that Finance attributes Chemotherapy and Radiotherapy costs to his own directorate to increase Chemotherapy's and Radiotherapy's profit margins from their respective national tariffs.

> *"[Finance] put the entire out of hours lab services, the entire out of hours radiology and the entire out of hours portering and physiotherapy services, for the whole hospital, in my budget… They make a lot of profit on Chemotherapy and Radiotherapy… because [that]'s what the main business of this organisation is… The labs, out of hours stuff, it's all Critical Care's expense… It's a direct contract with commissioners. It's not part of the national tariff for Critical Care..."* [CD1-G]

This strategy, according to the medical manager, enables them to inflate Critical Care's bed day costs and overcharge the local commissioners on the specific services which are reimbursed on local tariffs.

> *"We charge commissioners about £3,500 a bed day… I know what my nursing salaries cost. I know what my medical staff cost. And, I can tell you, that practically speaking, our bed day costs, for ourselves, including lab costs, or whatever, is probably […] about* £1,300, £1,400, £1,500. Depending on the case. Not £3,500." [CD1-G]

In a second example, a medical manager explained in detail a hypothetical scenario where he increased his specialty's income through intentionally increasing his patients' length-of-stay to reach a higher tariff threshold. The medical manager commented:

> *"I send 14,000 of my patients home in one day… At one of our big meetings. I said, "Most of these people I'm sending home at 20 hours. It's no problem for me to keep them until the afternoon and make this 24 hours. I can change that 14,000 home in one day to 6,000 if you want". I could increase [our income] by 30-40% with a little bit of judicious timing."* [CD2-B]

In these examples, clearly, strategizing, in pursuit of service line profitability may compromise patient care, impact on the hospital and the public sector as a whole.

Strategizing via competing practices

Third, medical managers strategize via competing practices to compare and compete against other specialties and neighbouring hospitals, compete for resources and improve their specialties' financial position. For example, a medical manager at Alpha describes how his specialty invested in new equipment to compete against other hospitals, assess market needs, increase profitability and improve the patient experience.

> *"…[N]eighbouring hospitals haven't got a fibrous scanner either… So what you can do is buy your fibrous scanner because it's going to make our clinics more profitable, it makes it better for the patients because they're not having to travel, but then you can bring in income from other [hospitals] themselves…"* [CD2-A]

Second, our analysis revealed that medical managers compete against other specialties through comparing costs and profitability between them. The strategic intent of such behaviour can be identified in trying to attract investment money, as the following quote from the medical manager of Ophthalmology suggests.

> *"The week that I got the news that [Ophthalmology]'d made £1.2 million profit, we also needed £800 for some computer network points in the department, and we were told, "You can't have the £800, there's no money there… I did once at some major meeting ask the*

question, "Well, could you tell us who's making the money?"… "Could you please tell me how much Orthopaedics makes?" [CD1-D]

Our analysis further identified competing practices within specialties. For example, a medical manager at Beta indicates:

"Like the antenatal subgroup might say, "We reviewed our order sets and we've saved £30,000." And the postnatal subgroup might say, "Ha, we reviewed ours and we saved £40,000." [CD3-B]

Consistent with our analysis, the Finance Director of Delta summarizes the intent behind medical managers' competing practices. He claims that medical managers compete via comparing specialties' performance and employing profitability information to disempower their competition and persuade Finance to invest in their services.

"I think there's a variety of motivations, – the first one not to be sniffed at is "I think I'm better than Mr X," or, "My specialty's better than specialty Y and I need this information to prove it." Yeah? Two is, "I think my specialty makes lots of money but I'm not getting any investment. So I want to prove that I'm making lots of money to help argue with management that I should get more investment in my service." [FD-D]

In such competing practices, medical managers' strategic intent was aligned with the organizations' strategy on improving cost efficiency, reducing overspending and achieving cost improvement targets.

The role of artefacts and tools in strategizing

Our second research question asks "*Which strategy tools and artefacts do medical managers use in their strategizing*?". In addressing this question, we search for strategic praxis, i.e. the micro-activities involved in medical managers' strategizing practices. Our analysis focuses on two artefacts and tools which medical managers often used in their strategizing, namely business cases and bubble charts.

Strategizing with business cases

First, our findings suggest that medical managers use business cases when they compete for resources to purchase new equipment, develop new facilities or recruit new staff. Business cases became strategic praxis when medical managers used them in tandem with competing practices to realise their intent on improving the financial positioning of their specialties and respond to efficiency pressures regarding the loss-making nature of specialties or services.

Business cases, at their earliest stages, derive out of medical managers' own initiatives through identifying a clinical need, an area for improvement or an investment opportunity. The initial idea is discussed among clinicians and a decision is made whether the clinical reasoning behind such an investment is sound. Then, they discuss such ideas with their business managers to identify the costings and flesh out the investment initiative in a formal manner via a business case which highlights both the clinical and business aspects of the actions involved.

Business cases are socio-material artefacts that help in communicating complicated meanings, in analysing and selecting between different options (Jarzabkowski et al., 2013). Medical managers in all four case study sites often used business cases to legitimize investments, by displaying objectivity, transparency, competence and occasionally disempowering adversaries (cf. Denis et al., 2006). For example, medical managers at Alpha used business cases to fast track the appointment of new consultants and hire them prior to competing hospitals.

> *"What you can do with [business cases] is make very rapid decisions within a couple of weeks and go out to advert, and appoint before the other hospitals even get a business case approved."* [CD2-A]

Strategizing resulted in a pilot which demonstrated how these consultants could be employed.

> *"We did a pilot showing that if a consultant, acute physician, takes the referrals from the Primary Care Team, you know, the GPs and the A&E department, you can deflect away, i.e. with just advice, about 10% of the patients. But to do that seven days a week requires an investment of around £350,000."* [CD2-A]

However, strong investment arguments can also follow an informal route towards obtaining approval. In the following example, the medical manager explains how he was able to achieve this large investment of £350,000 by simply devising an impromptu business case along with a commissioner.

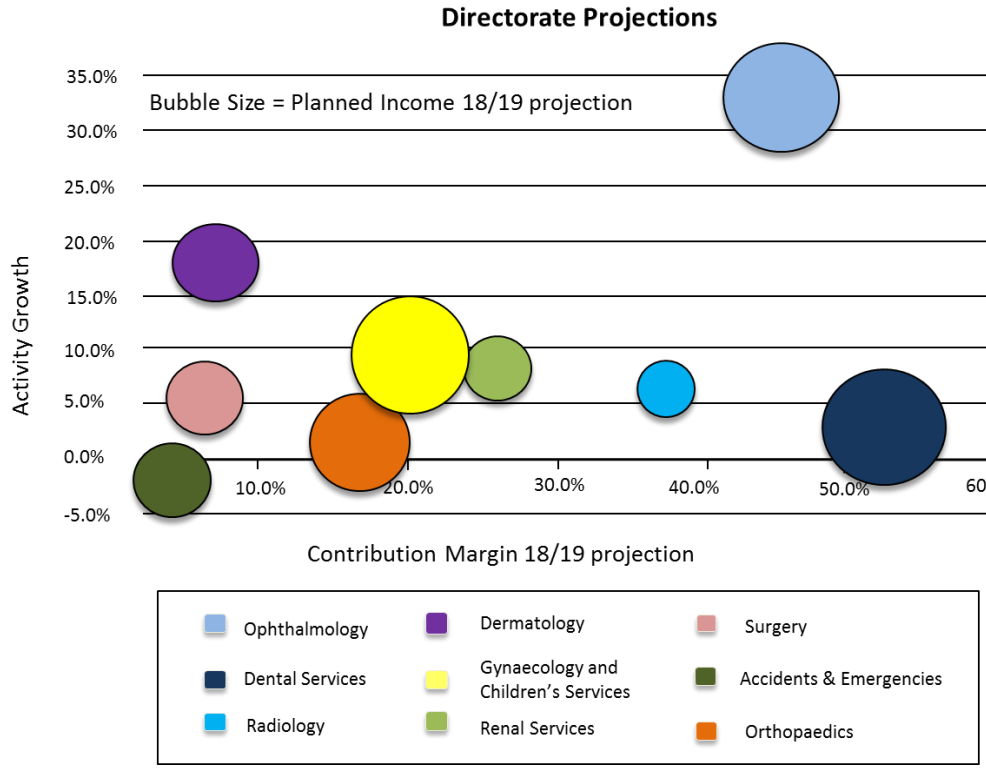
> *"The business case for £350,000 was a fag packet… Literally, we were at a meeting and the meeting was rubbish and there was myself, our service manager and one of the commissioners, and we were bored so we had a coffee, and on the back of a cigarette packet, we wrote down how a simple test of change could stack up over the course of a year. So that was our business case. There was nothing in writing, other than what was written on a scrap of paper."* [CD2-A]

Overall, our empirical evidence suggests that the use of business cases as strategic praxis facilitated an understanding of the clinical need for investments to take place, fostered creative thinking and helped in achieving a consensus for how investments should materialize (Heracleous and Jacobs, 2008).

Strategizing with bubble charts

Second, we identified the praxis of strategizing with bubble charts in both controlling and competing practices. In general, medical managers in all case study sites commonly used bubble charts to visualize and highlight comparisons amongst the financial performance of different specialties through coloured bubbles. The bubble chart of figure 2 is an example of how hospitals compare the activity growth and contribution margins of their specialties.

Figure 2. Example of a bubble chart



Medical managers used bubble charts to communicate complicated notions such as activity growth and contribution margin to clinicians, promote competition and engage them with CIP targets and service line profitability. For example, a medical manager describes his interpretation of the bubble charts he received and indicates that a good positioning on the chart helps him set performance targets.

> *"In simple terms, if you're up there you're good, if you're down there you're bad, and then the size of your bubble is the size of your department in comparison to the area… So you see something like Urology down here or other specialities, you want to be seen up here."* [CD1-D]

In a second example, a medical manager used bubble charts to motivate clinicians to improve efficiency, for example, theatre utilization, and thus grow the specialty's bubble (i.e. increase income) and move it up the chart.

> *"We show [clinicians] [bubble charts] all the time because we started off here […] with these two services higher than us… And as we […] started to pull the finances apart, our positioning increased… And [other services'] inefficiencies became apparent, driven by us saying, "Well, hang on a minute; we're using our theatres to 99% efficiency and they're using them to 76, so their figures can't be quite right". And it helped us turn it round."* [CD3-A]

Finally, bubble charts were also mobilised as strategic tools to visualize and communicate the relative performance of service lines through bubbles and, thus, motivate clinicians to improve performance. For example, a business manager at Delta commented on "*cash cow*" specialties which are positioned on the top right-hand corner of the bubble chart and is where other specialties aspire to reach.

> *"[Clinicians knew] which were the cash cows and which were making most profit and the most contributing specialty… [T]hey have a vehicle now to actually quantify those trends in those assertions they knew in the past but couldn't basically say, "Here are the numbers - go for it."* [BM-D]

Overall, bubble charts, as artefacts which measure and display performance promoted strategizing towards service line profitability through controlling both costs and activity and introducing competition between specialties.

Medical managers' strategizing implications

Our third research question asks "*What are the implications of medical managers' strategizing on the organization and the public sector*?". We draw on our evidence from the two sections above to address this question by discussing the implications of the identified strategizing practices and praxis on the specialty, the hospital and the public sector as a whole.

Our findings highlight that medical managers strategize via controlling, contesting and competing practices to achieve a multitude of objectives and materialize both organizational and divisional strategies. These strategies, however, which are driven by both clinical need and financial performance, are often conflicting. In controlling and competing practices, our analysis reveals an alignment between organizational objectives and medical managers' strategic intent. Medical managers attempt to control expenditure on prescribed drugs and investigations, attract resources, increase activity and cost-efficiency to consolidate both divisional and organizational cost improvement targets. Simultaneously, controlling and competing practices were concordant with improvements in quality of care, mostly due to medical managers reducing patient overtreatment.

However, in contesting practices, we identify instances of strategic disparity between specialties, the hospital and the public sector as a whole. Specifically, medical managers engaged in practices which prioritized the financial performance of their own specialties, such as through gaming with the tariff. When strategizing occurs outside of formal settings, it is not subject to oversight because the setting is informal, private and relies on individual professional judgement during everyday routine practices (Hoon, 2007). Under this context, medical managers have the knowledge and power to intervene on the income side, for example through negotiating with commissioners for a better local tariff, prolonging patients' length-of-stay and inflating treatment costs to negotiate a higher local tariff. Consequently, perverse incentives exist for medical managers to strategize via contesting practices and overlook proper clinical practice in favour of service line profitability, which is hardly conducive to good patient care and use of public resources.

Furthermore, strategizing via contesting practices does not necessarily translate into benefit for the hospital as a whole. Such examples demonstrate that a specialty which operates as a separate business unit can lower its costs to increase its reported profit but, thereby, may raise the costs of other areas in the hospital. In addition, strategizing with bubble charts to promote increased activity engenders the risk of simply augmenting loss-making activity, if the tariff is less than the cost of treatment. Thus, such practices and praxis are not necessarily aligned with 'best value' demonstrated for the specialty, the hospital or for the public sector.

Discussion and conclusions

This paper explored how medical managers 'do' strategic planning in their everyday activities and investigated which outcomes are tied to their strategizing practices and praxis. We employed a conceptual framing of practice-praxis-practitioners which allowed us to analyse and discuss the practices (controlling, contesting and competing), the praxis (bubble charts and business cases) and the implications of medical managers' strategizing behaviour. In doing so, the paper makes a theoretical contribution to SAP and public management studies on strategizing at the operational level. The paper has shown that what makes financial sense to medical managers strategizing in the local circumstances of their profit centres does not always translate to financial wisdom for the hospital as a whole. Equally, financial gain for the hospital may not equate to value for the local health economy or, indeed, for the public sector. Our findings on strategizing contribute to the current debate on the implications of strategic planning for public organizations.

Our study has important practical implications. First, it provides insight into how medical managers, professionals who are not trained strategists, construct and perform their own strategies. We highlight the practices and tools that they use in their day-to-day activities to improve clinical outcomes and the financial positioning of their specialty. For example, medical managers compete for resources and alleviate financial pressures from their specialties through strategizing with business cases, a powerful tool which is used to display competence and transparency. Second, our findings demonstrate that medical managers' strategizing practices and praxis may lead to multiple, divergent and conflicting strategic objectives which often benefit their own specialties but may be detrimental for other specialties, the hospital or the public sector as a whole. Consequently, managers who engage in such strategizing, and senior managers and policy-makers with an interest in strategic planning in public organizations, should be aware of these conflicts.

Future research should engage in comparative studies of cross-country analyses. The hybrid profession of medical managers is common among different healthcare systems such as Finland, Italy, Germany, Canada and Australia (e.g. Abernethy and Vagnoni; 2004; Jacobs, 2005; Kurunmäki, 2004). Furthermore, the English tariff-based payment system (PbR) shares many similarities with other countries' funding systems, either for reimbursement purposes, such as Portugal, France and Germany, or to facilitate planning and healthcare management, such as Sweden and Finland (Chapman et al., 2014; Busse et al., 2011). Thus, although many similarities exist between this study and other countries' healthcare systems and professional identity of medical managers, future research may take additional contextual factors into consideration when applying the practice-praxis-practitioner framework to other countries, such as socio-political forces, the structure of the healthcare system, clinicians' management training and funding policies.

Impact

Strategic planning is not only performed by senior managers and trained strategists. Middle managers also engage in strategic planning in their day-to-day activities, and their formulated strategies may align with or cut across the formal organizational strategic narrative. This paper provides practical insight into how medical managers of English hospitals strategize within their clinical directorates. It shows that their strategizing and use of strategic tools are fine-tuned to improve the profitability of their service lines and deliver on cost improvement targets. The authors suggest that strategizing at the directorate level engenders risks since patient care, cost control, the financial viability of the hospital as a whole and its public value may become subordinated to the narrow pursuit of service line profitability.

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